42 CFR 440.40(b) MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Unless otherwise indicated below, payment for EPSDT services is based on the established fee schedule unless a lower amount is billed.

Orthodontic Services
A fixed fee is paid for attaching the approved orthodontic appliance. In addition, a fixed fee is paid every three months for maintenance service. The maximum number of payments for maintenance is eight quarterly payments. Total payments for the appliance and for the maintenance service are limited to usual and customary charges.

Diagnostic, Preventive, Screening, and Rehabilitative Services

Early Intervention Services - Providers of early intervention services will be paid on a fixed monthly rate. The rate is based on historical cost for FY 1996 inflated forward annually using the UCPI-U all services index published by the U. S. Department of Labor. Payment is intended to cover all early intervention services outlined in the child's Individual Family Service Plan (IFSP). Providers may bill for the monthly rate when at least one face-to-face contact is made, but may only bill once in each month when services are given.

Skills Development Service - Payment is based on the average cost per day for services received. Historical costs are used to establish interim payments. Actual costs are used to determine final payment. Except for the first period of covered services, the cost settlement will be for a twelve month period. Allowable costs are defined by HCFA Pub. 15-1. Direct costs are defined as the total compensation, including benefits, of the staff who provide "hands-on" care. Total compensation for the direct staff at the school is divided between "academic educational" and "functional skills development and maintenance". Other costs are allocated using direct costs for "academic educational" and "functional skills". Total days are divided into the accumulated "functional skills" costs, including indirect cost allocations, to arrive at an average cost per day.

42 CFR 440.40(b)

Payment for Targeted Case Management Services for EPSDT Eligibles

Payment for targeted case management services for EPSDT eligibles is made on a fee-for-service basis. A separate prospective rate is established for each type of targeted case management provider identified below. In accordance with Federal Office of Management and Budget Circular No. A-87 requirements, payments made to governmental service providers shall not exceed the costs of providing such services.

Independent Professional: Rates are established on the basis of the historical cost of the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider without RMS Capability: Rates are established on the basis of the historical cost for the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U.S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider with RMS Capability: Rates are based on an enrolled agency's average allowable cost to provide a monthly unit of targeted case management services to an eligible recipient. Rates will be authorized for a period of 12 months. Except for the initial period, an agency's rate will be calculated as follows:

42 CFR 440.40(b) Payment for Targeted Case Management Services for EPSDT Eligibles (Continued)

Compute:	the Agency's actual total cost for the most recently completed 12 month period for which actual cost data exist, including (1) the salaries and benefits of case managers, their direct supervisory and support staff, and their indirect administrative staff, and (2) other operating costs including travel, supplies, telephone, and occupancy cost, and indirect administrative costs in accordance with Circular A-87. To determine the agency's "allowable costs", subtract from its total costs all personnel, operating, occupancy, and indirect administrative costs that are both unrelated to the delivery of Medicaid's scope of targeted case management services and are not allocated by the RMS.
Multiplied by:	the percentage of time spent by agency personnel performing Medicaid allowable targeted case management services and related indirect activities on behalf of clients, ages birth through 20 years (regardless of the client's Medicaid eligibility) during the 12 month period. This percentage is derived from random moment time studies (RMS).
Multiplied by:	the percentage of the agency's clients (regardless of Medicaid eligibility) who received a Medicaid allowable targeted case management service during the period.
Equals:	total allowable costs incurred by the agency to provide and support Medicaid's scope of targeted case management services.
Divided by:	12 months.
Equals:	the agency's average allowable monthly cost to provide and support Medicaid's scope of targeted case management services on behalf of individuals in the target group.
Divided by:	the average monthly number of the agency's clients in the target group (ages birth through 20 years regardless of Medicaid eligibility) who received a covered case management service during the period.
Equals:	the agency's monthly allowable cost per targeted case management recipient in the target group. This cost equals the monthly fee for service amount that the agency will be authorized to claim for each EPSDT eligible recipient in the target group who received one or more covered targeted case management services that month. Documentation of case management services delivered will be retained in the service worker case files.

When determining an agency's initial rate, the Medicaid agency will apply the same calculations described above, but may use less than 12 months of data in calculating the rate. This initial rate may be in effect for less than a 12 month period.

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PSYCHOLOGISTS

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fee schedule is developed from the paid claims history file.

42 CFR 440.40(b) MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Diagnostic, Screening, Preventive, and Rehabilitative Services

Mental Health Services

1. Skills development programs are reimbursed a daily payment rate.

   Comprehensive Residential programs - The daily payment rate for comprehensive residential programs is an all-inclusive rate that covers all diagnostic and rehabilitative services provided to Medicaid clients in the program.

   Group Homes - The daily payment rate for group homes covers mental health evaluations, individual and group therapy, individual and group behavior management, and skills development services. Other needed diagnostic and rehabilitative mental health services, including psychiatric evaluations, psychological testing, and medication management, are paid on a fee-for-service basis according to #2 below.

   Family-based foster care programs - The daily payment rate for family-based programs covers mental health evaluations and skills development services provided in the family-based program. Other needed diagnostic and rehabilitative mental health services, including psychiatric evaluations, psychological testing, individual and group therapy, individual and group behavior management, medication management, and skills development services provided in a treatment setting outside of the family-based program, are paid on a fee-for-service basis according to #2 below.

   Each of the three skills development program types will have a daily rate. The daily payment rate for Medicaid-covered services is a fixed rate paid for all Medicaid clients in the specified program. The daily payment rate is set prospectively using historical costs. Each year the rate will be inflated by an amount not to exceed the medical component of the CPI-U. Payment for up to eight absent days per month is allowed for skills development programs. Days the client is in a hospital, nursing facility, or detention center are not covered and may not be billed to Medicaid by the skills development program. The daily payment rate is net of room and board. Room and board costs are defined using IV-E definitions for each facility.

2. All other diagnostic and rehabilitative mental health services not covered in the daily payment rate, or that are provided to clients who are not in a skills development program, are paid using a uniform fee schedule. Services are defined by HCPC codes and priced using a fixed fee schedule. Payments are made on a fee-for-service basis. Payment will be the lower of the usual and customary charge or the fee schedule. The fee schedule is the same as that used for mental health clinics (see State Plan ATTACHMENT 4.19-B, page 25) as these are comparable service providers.

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PAYMENT FOR CHIROPRACTIC SERVICES

Payments for chiropractic services are made based on encounter rates. There are two encounter rates; one for the initial evaluation and one for subsequent treatments.

HCFA DIRECTIVE

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Payment for Services

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.